STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155210	A. BUILDING 00 B. WING	03/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE OF GREENSBURG	410 PARK ROAD GREENSBURG, IN47240

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F0000	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 2/16/11. Survey Dates: March 28 and 29, 2011 Facility number: 000117 Provider number: 155210 AIM number: 100266460 Survey team: Diana Sidell RN, TC Janie Faulkner RN Census bed type: SNF/NF: 70 Total: 70 Census payor type: Medicare: 6 Medicaid: 43 Other: 21 Total: 70 Sample: 9 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 4/04/11 by Suzanne Williams, RN	F0000	Please accept this Plan of Correction as allegation of the deficiencies noted in the 2567 for Heritage House of Greensburg. In submitting this Plan of Correction, Heritage House is not admitting to the allegations of non-compliance contained within.	
F0223	The resident has the right to be free from verbal, sexual, physical, and mental abuse,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.			
SS=D	Based on record review and interview, the facility failed to identify a resident who had hypersexual behaviors (resident #91) and to prevent resident to resident sexual abuse for 1 of 1 resident reviewed for abuse in a sample of 9. (Resident #90) Findings include: A policy and procedure for "Incidents of Alleged Abuse", with an initial date of February 2008, was provided by the Director of Nursing on 3/28/11 at 4:02 p.m. The policy indicated, but was not limited to: "PURPOSE: To ensure that each resident is free of physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect, and involuntary seclusion. POLICY: Residents residing in this facility will be treated with dignity and respect in accordance with their individual needs. They will not be subjected to physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect, and involuntary seclusion...PREVENTION/IDENTIFICATION OF POTENTIAL ABUSE: Residents who exhibit abusive behavior:	F0223	It is the practice of this facility to keep all resident free form verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. Resident # 90 has not demonstrated any negative outcome from this episode regarding resident # 91. Resident #90 has NOT been the recipient of any episodes since this isolated incident.Resident #90 now has a lap throw blanket over her while up in chair due to the nature of which resident #91 had put is his hand between her fully clothed legs. Resident #90 does not have the ability to control movements or positioning due to diagnosis of Huntington's chorea. A stop sign mesh barrier is placed across the doorway of her room and has an alarm that sounds if the barrier is removed or walked through. If for some reason upon re-evaluation of this it is ineffective a motion sensor alarm will be trialed.All other residents in this facility have the potential to be affected by this defiant practice, however no other resident has been affected. The continuous process of evaluations, observation, education and auditing of residents will continue Staff and families will be conducted to	04/28/2011

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	Ensure that all residents with a significant history of aggression have been assessed and care plan interventions documented to provide staff with appropriate information." 1. Resident #91's record was reviewed on 3/28/11 at 1:15 p.m. The record indicated resident #91 was admitted with diagnoses that included, but were not limited to, bipolar disorder, dementia, cognitive impairment, depression, insomnia, paranoid schizophrenia, and hypersexual behavior. An admission minimum data set assessment, dated 1/24/11, indicated resident #91 was moderately cognitively impaired, was able to make himself understood, usually understands others, and ambulated with a rolling walker without assistance. A "Preadmission Screening and Resident Review (PASRR)" dated 1/14/11 indicated resident #91 was ambulatory, used a wheelchair or walker, was confused/disoriented, had primary diagnoses of dementia, paranoid schizophrenia, hypersexual behavior, and depression, and needed 24 hour supervision and assist with activities of daily living.		ensure all are free from abuse.This will be done by:1) Completing a thorough pre-admission assessment of any potential residents and if identified as a possible threat to other residents in any manner it will be determined if the facility can meet the needs of the resident AND keep others free from ANY form of abuse. If the facility does not feel it can accomplish this then the resident will be denied admission. If the facility determines it CAN meet the needs of the resident we will measures in place to ensure the safety of other residents. Should facility admit resident with history of sexual behavior, it will be noted in the care plan upon admission. Appropriate interventions will be noted immediately with appropriate preventions in place at time of admission. This will be re-evaluated with each potentially threatening resident. It will be discussed with department heads, specifically D.O.N. and Social Service Director but ultimately the decision of the Administrator.2) If a resident has a known history of abusive behaviors the facility will ensure the resident is seen by the proper discipline i.e. The Psychologist and mental health professionals. The facility will follow the recommendations of these professionals and notify them immediately if medications or other interventions are	

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	A medical record discharge summary, dated 1/14/2011, from a hospital visit indicated: "REASON FOR ADMISSION: DEMENTIA NH (NURSING HOME) PLACEMENT...PRIMARY DIAGNOSIS (Diagnosis or condition that was treated): 1. Hypersexual behavior/ depression 2. Dementia (Alzheimers versus mixed)...PERTINENT HISTORY AND PHYSICAL FINDINGS: Pt (patient)...h/o (history of) dementia/cognitive impairment...paranoid schizophrenia, CKD (chronic kidney disease), depression, and prostate cancer who was brought in by [family member] after being "kicked out of his nursing home"...Per pt's records, [family member] has noticed increasing sexual preoccupation for the past six months and pt has become sexually aggressive towards female employees and residents at his current ECF (extended care facility). Pt reportedly grabbed another female resident's chest two weeks ago, and was sent to [psych hospital] where he was hospitalized...then transferred back to his ECF and given a "second chance". Tonight, however, pt was caught kissing the same female resident, and pt was "kicked out" of the facility. Pt currently alert and is able to describe the incident in detail, but he fails to see "what the big deal is" and, pt reports other ECF resident		ineffective.3) The facility will continue to use our behavior monitoring form and tracking methods for any existing or new abusive behaviors. These will be dealt with immediately if any behaviors occur, otherwise the behaviors will be summarized and documented on a monthly basis, prn and with Behavior Management Team for effectiveness.4) The Consultant Pharmacist will review all medications monthly. The Behavior Management Team (including the pharmacist, psychologist, social service and nursing) will evaluate medications and side effects quarterly and more often if necessary and follow up on any recommendations from the Behavior Management Team, and will also follow up on any pharmacist, mental health consultant recommendations, notify Physician as well as process orders and interventions including updating the plan of care.5) All staff will be re-educated on the proper policy and procedure to prevent/report abuse including sexual abuse and the measures to take if it does occur. This will be conducted now and then quarterly thereafter.6) The behavior monitoring Quality Assurance/Improvement tool (Attach) will be done on all residents by 4/28/11, and then will be done on a random sample of at least 10% of the residents on a	

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	was an active participant. ECF transfer records also report hx (history) of pt inappropriately grabbing self in front of female staff...." Social Service Notes dated 1/23/11 indicated: "Admission assessment complete today & on chart. Has adjusted well to NF (nursing facility) & staff. D/T (due to) score 12/15 on depression scale - will have nrsg. (nursing) obtain order for res. (resident) to see [psychologist]. DNR (do not resuscitate) code status & no current plan for D/C (discharge). No sexual behaviors noted. Will cont[inue] to observe, assess & meet res. needs." Nurse's notes dated 3/15/11 at 12:50 p.m. indicated: "At approx[imately] 12:30 p.m., CNA noted res[ident] in hallway, heading towards MDR (main dining room). She stated she said "hi" to him. She walked one more room & asked another staff member what he was doing. The other staff member stated to get [resident #91], he just went into her room. CNA turned & immediately went to female's room. As she approached, she called out his name. He turned. She noticed female sitting in her chair, fully clothed with [resident 91's] hand between female's fully clothed legs. She told res to stop. CNA approached & removed his hand away from female. Explained not		monthly basis indefinitely. 7) The results of the Quality Assurance Tool audits and Behavior Meeting will be presented to the Quality Assurance Committee and any recommendations made will be followed. Resident #91 has had the following adjustments or interventions to prevent him from any further sexual advances in the future.-Depakote ER 250mg HS 3/24/11-Depovera 150mg q 2weeks IM 3/29/11 -Decreased Lexapro to 10 mg qd on 04/07/11 per psychologist recommendation.-Every 15minute visual checks done and documented on his whereabouts until determined by IDT that it is no longer necessary-Behavior tracker continued, care plan initiated and revised. A 1:1 discussion with Resident #91 regarding inappropriate vs. appropriate behavior. Instructing resident he is not to enter other residents' rooms uninvited-On 3/28/11 The V.A. Hospital evaluated resident #91 for behaviors and psych issues and opted not to admit him, deeming him safe and appropriate to return to nursing facility with other dependent residents.-The MD, Pharmacist, Psychologist, and facility Behavior Management Team have all reviewed the resident in all aspects are confident the resident is safe to remain at the facility. His Depovera is NOW noted NOT to be discontinued or have an	

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	appropriate. CNA escorted him out of female's room. He went on to dining room to eat lunch...." Social Service Notes dated 3/15/11 indicated: "Res. was observed by CNA [#1] & [QMA #2] going into res. room [resident #90]. When CNA [#1] entered room [resident #90's room number]she observed this res. [with] hand between legs of res. [#90]. CNA immed. redirected male res. (#91) away from female res.[#90] & out of room. This writer was informed of this by chg. nurse, [name of nurse]. When writer went to speak [with] CNA [#1] writer walked past female res room [#90] & observed her sitting facing doorway in w/c in inapprop. way (see female res. chart SS (Social Service) note 3/15/11). This res. has had no sexually inapprop. behaviors in this NF & per chg. nurse, CNA's & this writer's observations has never entered another res. room...." A "Facility Incident Reporting Form" dated 3/15/11 indicated the preventive measures taken were: "[Resident #91] will continue to be followed by [psychologist]. [Resident #91] will be seen by [psychologist] at his next visit. Will do a medication review on [Resident #91]. [Resident #91 does not have a history of going into other resident's		interuption of therapy unless specifically ordered by MD to do so and why. Deprovera is know to be proven to be effective in surpressing the sexual desires. All of this has been or will be completed by 4/28/11.	

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	rooms. However, if he is noted going into other resident's rooms uninvited, he will be encouraged to leave. [Resident #91] has not had any previous episodes of inappropriate sexual behaviors at our facility. [Resident #90] wears pants at all times, which we will continue to do. Will ask [Resident #90's] family about the possibility of moving her to a different room or rearranging her room somewhat due to her body positioning. Care plans will be updated." On 3/28/11 at 4:05 p.m., the Director of Nursing indicated she was not sure if they knew resident #91 had any behaviors upon admission, but they knew he had dementia. On 3/28/11 at 4:10 p.m., the Social Service Director indicated she was not aware of the behavior [hypersexual] until this incident with resident #90, but knew he had been at three other facilities before admission here. On 3/29/11 at 4:18 p.m., the Director of Nursing indicated resident #91 had no behavior care plan in place after admission, and they had put the current behavior care plan in place after the incident on 3/15/11. 2. Resident #90's record was reviewed on			

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	3/28/11 at 12:45 p.m. The record indicated resident #90 was admitted with diagnoses that included, but were not limited to, depression, end stage Huntington's disease, expressive aphasia (cannot speak), and rigidity. A quarterly minimum data set assessment dated 3/20/11 indicated resident #90 was severely cognitively impaired, had no speech, did not recognize family members, and was totally dependant on staff for all care. Social Service Notes dated 3/15/11 (no time documented) indicated: "Res. does not appear to have any adverse reaction to incident today involving male res. This was reported to ISDH d/t sexually inapprop[riate]. This writer observed this res. sitting in w/c in her room, facing doorway [with] legs in contracted [up] ben @ knees position & spread apart (as this is norm. positioning for res. d/t ES (end stage) Huntington's). Res. was fully clothed however, no lap blanket on. Lap blanket was placed on res. & she was positioned away from doorway, facing T.V. Res. [with] ES Huntington's, does not speak, makes no decisions for self & is dependent for all ADL's. Does not appear to even recall that male res. was in room...."			

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F0226 SS=D	3.1-27(a)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement the abuse prohibition policy and procedure related to prevention and identification of potential abuse for one resident admitted with a diagnoses of hypersexual behavior (Resident #91). This affected 1 of 1 resident reviewed for abuse in a sample of 9. (Resident #90) Findings include: A policy and procedure for "Incidents of Alleged Abuse", with an initial date of February 2008, was provided by the Director of Nursing on 3/28/11 at 4:02 p.m. The policy indicated, but was not limited to: "PURPOSE: To ensure that each resident is free of physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect, and involuntary seclusion. POLICY: Residents residing in this facility will be treated with dignity and respect in accordance with their individual needs. They will not be subjected to physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect, and involuntary	F0226	It is the practice of this facility to keep all resident free form verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. Resident #90 has not experienced and negative outcomes from this deficient practice and has been addressed as stated in F 223 of this plan of correction. Resident #91 has had the following adjustments or interventions to prevent him from any further sexual advances in the future. -Depakote 250mg HS 3/24/11-Depovera ER 150mg q 2 weeks IM 3/29/11 -Decreased Lexapro to 10 mg qd on 04/0711 per psychologist recommendation. -Every 15minute visual checks done and documented on his whereabouts until determined by IDT that it is no longer necessary-Behavior tracker implemented, care plan initiated and revised. A 1:1 discussion with Resident #91 regarding inappropriate vs. appropriate behavior. Instructing resident he is not to enter other residents' rooms uninvited-On 3/28/11 The V.A. Hospital evaluated resident #91 for behaviors and psych issues and opted not to admit him, deeming him safe and appropriate to return to nursing facility with other	04/28/2011

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	seclusion...PREVENTION/IDENTIFICATION OF POTENTIAL ABUSE: Residents who exhibit abusive behavior: Ensure that all residents with a significant history of aggression have been assessed and care plan interventions documented to provide staff with appropriate information." 1. Resident #91's record was reviewed on 3/28/11 at 1:15 p.m. The record indicated resident #91 was admitted with diagnoses that included, but were not limited to, bipolar disorder, dementia, cognitive impairment, depression, insomnia, paranoid schizophrenia, and hypersexual behavior. An admission minimum data set assessment, dated 1/24/11, indicated resident #91 was moderately cognitively impaired, was able to make himself understood, usually understands others, and ambulated with a rolling walker without assistance. A "Preadmission Screening and Resident Review (PASRR)" dated 1/14/11 indicated resident #91 was ambulatory, used a wheelchair or walker, was confused/disoriented, had primary diagnoses of dementia, paranoid schizophrenia, hypersexual behavior, and depression, and needed 24 hour		dependent residents.-The MD, Pharmacist, Psychologist, and facility Behavior Management Team have all reviewed the resident in all aspects are confident the resident is safe to remain at the facility. His Depovera is NOW noted NOT to be discontinued or have an interuption of therapy unless specifically ordered by MD to do so and why. Deprovera is know to be proven to be effective in surpressing the sexual desires. All other residents in this facility have the potential to be affected by this defiant practice, however no other residents have been affected. The continuous process of evaluations, observation, education and auditing of residents will continue. Staff and families will be conducted to ensure all are free from abuse.This will be done by:1) Completing a thorough pre-admission assessment of any potential residents and if identified as a possible threat to other residents in any manner it will be determined if the facility can meet the needs of the resident AND keep others free from ANY form of abuse. If the facility does not feel it can accomplish this then the resident will be denied admission. If the facility determines it CAN meet the needs of the resident we will measures in place to ensure the safety of other residents. Should facility admit resident with history	

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	supervision and assist with activities of daily living. A medical record discharge summary, dated 1/14/2011, from a hospital visit indicated: "REASON FOR ADMISSION: DEMENTIA NH (NURSING HOME) PLACEMENT...PRIMARY DIAGNOSIS (Diagnosis or condition that was treated): 1. Hypersexual behavior/ depression 2. Dementia (Alzheimers versus mixed)...PERTINENT HISTORY AND PHYSICAL FINDINGS: Pt (patient)...h/o (history of) dementia/cognitive impairment...paranoid schizophrenia, CKD (chronic kidney disease), depression, and prostate cancer who was brought in by [family member] after being "kicked out of his nursing home"...Per pt's records, [family member] has noticed increasing sexual preoccupation for the past six months and pt has become sexually aggressive towards female employees and residents at his current ECF (extended care facility). Pt reportedly grabbed another female resident's chest two weeks ago, and was sent to [psych hospital] where he was hospitalized...then transferred back to his ECF and given a "second chance". Tonight, however, pt was caught kissing the same female resident, and pt was "kicked out" of the facility. Pt currently		of sexual behavior, it will be noted in the care plan upon admission. Appropriate interventions will be noted immediately with appropriate preventions in place at time of admission. This will be re-evaluated with each potentially threatening resident. It will be discussed with department heads, specifically D.O.N. and Social Service Director but ultimately the decision of the Administrator.2) If a resident has a known history of abusive behaviors the facility will ensure the resident is seen by the proper discipline i.e. The psychologist and mental health professionals. The facility will follow the recommendations of these professionals and notify them immediately if medications or other interventions are ineffective.3) The facility will implement the behavior monitoring form and tracking methods for any existing or new abusive behaviors. These will be dealt with immediately if any occurrences otherwise the behaviors will be summarized and documented on a monthly basis, prn and with each care plan conference for effectiveness.4) The Consultant Pharmacist will review all medications monthly. The interdisciplinary team (including psychology, pharmacy, social service and nursing) will evaluate medications and side effects monthly also they will follow up on any pharmacist,	

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	alert and is able to describe the incident in detail, but he fails to see "what the big deal is" and, pt reports other ECF resident was an active participant. ECF transfer records also report hx (history) of pt inappropriately grabbing self in front of female staff...." Social Service Notes dated 1/23/11 indicated: "Admission assessment complete today & on chart. Has adjusted well to NF (nursing facility) & staff. D/T (due to) score 12/15 on depression scale - will have nrsg. (nursing) obtain order for res. (resident) to see [psychologist]. DNR (do not resuscitate) code status & no current plan for D/C (discharge). No sexual behaviors noted. Will cont[inue] to observe, assess & meet res. needs." Nurse's notes dated 3/15/11 at 12:50 p.m. indicated: "At approx[imately] 12:30 p.m., CNA noted res[ident] in hallway, heading towards MDR (main dining room). She stated she said "hi" to him. She walked one more room & asked another staff member what he was doing. The other staff member stated to get [resident #91], he just went into her room. CNA turned & immediately went to female's room. As she approached, she called out his name. He turned. She noticed female sitting in her chair, fully clothed with [resident 91's] hand between		mental health consultant recommendations, notify Physician as well as process orders and interventions including updating the plan of care.5) All staff will be educated on the proper policy and procedure to prevent/report abuse including sexual abuse and the measures to take if it does occur. This will be conducted now and then quarterly thereafter.6) The behavior monitoring Quality Assurance/Improvement tool (see Attachment) will be done on all residents by 4/28/11, and then will be done on a random sample of at least 10% of the residents on a monthly basis indefinitely. 7) The results of the Quality Assurance Tool audits and Behavior Meeting will be presented to the Quality Assurance Committee and any recommendations made will be followed. The completion date for this is 4/28/11	

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	155210	A. BUILDING 00 B. WING	03/29/2011

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	female's fully clothed legs. She told res to stop. CNA approached & removed his hand away from female. Explained not appropriate. CNA escorted him out of female's room. He went on to dining room to eat lunch...." Social Service Notes dated 3/15/11 indicated: "Res. was observed by CNA [#1] & [QMA #2] going into res. room [resident #90]. When CNA [#1] entered room [resident #90's room number]she observed this res. [with] hand between legs of res. [#90]. CNA immed. redirected male res. (#91) away from female res.[#90] & out of room. This writer was informed of this by chg. nurse, [name of nurse]. When writer went to speak [with] CNA [#1] writer walked past female res room [#90] & observed her sitting facing doorway in w/c in inapprop. way (see female res. chart SS (Social Service) note 3/15/11). This res. has had no sexually inapprop. behaviors in this NF & per chg. nurse, CNA's & this writer's observations has never entered another res. room...." A "Facility Incident Reporting Form" dated 3/15/11 indicated the preventive measures taken were: "[Resident #91] will continue to be followed by [psychologist]. [Resident #91] will be seen by [psychologist] at his next visit.			

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	Will do a medication review on [Resident #91]. [Resident #91 does not have a history of going into other resident's rooms. However, if he is noted going into other resident's rooms uninvited, he will be encouraged to leave. [Resident #91] has not had any previous episodes of inappropriate sexual behaviors at our facility. [Resident #90] wears pants at all times, which we will continue to do. Will ask [Resident #90's] family about the possibility of moving her to a different room or rearranging her room somewhat due to her body positioning. Care plans will be updated." On 3/28/11 at 4:05 p.m., the Director of Nursing indicated she was not sure if they knew resident #91 had any behaviors upon admission, but they knew he had dementia. On 3/28/11 at 4:10 p.m., the Social Service Director indicated she was not aware of the behavior [hypersexual] until this incident with resident #90, but knew he had been at three other facilities before admission here. On 3/29/11 at 4:18 p.m., the Director of Nursing indicated resident #91 had no behavior care plan in place after admission, and they had put the current behavior care plan in place after the			

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	incident on 3/15/11. 2. Resident #90's record was reviewed on 3/28/11 at 12:45 p.m. The record indicated resident #90 was admitted with diagnoses that included, but were not limited to, depression, end stage Huntington's disease, expressive aphasia (cannot speak), and rigidity. A quarterly minimum data set assessment dated 3/20/11 indicated resident #90 was severely cognitively impaired, had no speech, did not recognize family members, and was totally dependant on staff for all care. Social Service Notes dated 3/15/11 (no time documented) indicated: "Res. does not appear to have any adverse reaction to incident today involving male res. This was reported to ISDH d/t sexually inapprop[riate]. This writer observed this res. sitting in w/c in her room, facing doorway [with] legs in contracted [up] ben @ knees position & spread apart (as this is norm. positioning for res. d/t ES (end stage) Huntington's). Res. was fully clothed however, no lap blanket on. Lap blanket was placed on res. & she was positioned away from doorway, facing T.V. Res. [with] ES Huntington's, does not speak, makes no decisions for self & is dependent for all ADL's. Does not			

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	appear to even recall that male res. was in room...." 3.1-28(a)			